

INDEPENDENT MEMBERSHIP APPLICATION

Independent Member Information

This person participates in Partnership activities as an interested member.

Individual's Name: _____

Mailing Address: _____ Physical Address: _____

Phone: _____ Fax: _____ E-mail: _____

Your signature indicates that you agree to comply with membership requirements and bylaws.

Signature

Date

Administrative Assistant

Please indicate if there is an additional person through whom you would like us to correspond.

Assistant's Name: _____

Phone: _____ Fax: _____ E-mail: _____

Committee Selection

Please select the committee(s) with which you would like to be involved.

- ☐ **Primary Prevention Committee:** Works to reduce or eliminate exposure to risk factors and promote protective factors.
- ☐ **Secondary Prevention Committee:** Works to reduce morbidity and mortality by identifying disease early and providing appropriate treatment.
- ☐ **Medical Care Committee:** Works to improve quality of and access to cancer treatment and care.
- ☐ **Membership/Communications** ☐ **Policy and Legislation** ☐ **Evaluation**
- ☐ **Colon Cancer Task Force** ☐ **Prostate Cancer Task Force**

Please return completed application to

Megan Roberts, Partnership Coordinator
Washington State Department of Health
Comprehensive Cancer Control Program
P.O. Box 47855
Olympia, WA 98504-7855

If you have questions regarding this application, please contact Megan Roberts at 360-236-3785 or megan.roberts@doh.wa.gov